



Application for participation in CAST programs

Name _____

Business
Address _____

Home
Address _____

Business
Phone (____) _____

Home
Phone (____) _____

Beeper # _____

Emerg. Phone (____) _____

Date of Birth _____

Spouse's Name _____
(optional)

Social Security # _____

Email Address _____

Application for advanced training in _____

DOCUMENTS TO BE MAILED:

- Signed Participation Agreement
- Pages 8 and 9 of Application (with required initials and signatures)
- Curriculum Vitae
- Current Malpractice Insurance Certificate
- Copy of Ohio Special Activities License (if not currently licensed in the state of Ohio)
- Registration Fees payable to The Cleveland Clinic, c/o Center for Advanced Skills Training

MAIL DOCUMENTS TO:

The Cleveland Clinic Foundation
Center for Advanced Skills Training, E 32
9500 Euclid Avenue
Cleveland, OH 44195

If you have any questions, please call the CAST office at (216) 445-5601

THE CLEVELAND CLINIC FOUNDATION
Application for participation in CAST programs

Please respond to all questions that are applicable. Application must be submitted prior to initial consideration by the CAST Advisory Board. Submit all information to:

The Cleveland Clinic Foundation
Center for Advanced Skills Training, E 32
9500 Euclid Avenue
Cleveland, OH 44195

Name _____

Business Address _____ Home Address _____

Business Phone (____) _____ Home Phone (____) _____

Beeper # _____ Emerg. Phone (____) _____

Date of Birth _____ Spouse's Name _____ (optional)

Social Security # _____ Email Address _____

PROGRAM APPLICATION

Application for advanced training in _____

Describe past and current experience/expertise in the requested field of training (Attach supporting documents)

Have you had previous training in this or a similar program? Yes No

If yes, list the programs and dates attended (Attach supporting documents)

Program _____	Date _____
Program _____	Date _____
Program _____	Date _____
Program _____	Date _____

Preferred dates for training _____

Briefly describe your expectations from the program:

Do you need assistance with lodging? Yes No

Do you need assistance with transport? Yes No

VISA STATUS

U.S. Citizen? Yes No
Permanent Visa? Yes No Number _____
Temporary Visa? Yes No Type (H1B, J1?) _____ Expiration Date _____
Number _____ Expiration Date _____

MEDICAL MALPRACTICE CARRIER (Attach copy of insurance certificate)

Name of Insurer: _____
Address: _____

PROFESSIONAL LICENSE OR REGISTRATION Please list **all** states in which you have been licensed or registered.

Ohio # _____ Exp. Date _____
Other # _____ Exp. Date _____
Other # _____ Exp. Date _____
Other # _____ Exp. Date _____

DEA REGISTRATION

DEA # _____ Issue Date _____ Exp. Date _____

SPECIALTY & BOARD CERTIFICATION INFORMATION

For each specialty listed below, please indicate if you are qualified or board certified.

PRIMARY SPECIALTY _____ Qualified Certified Does not apply
Certifying Board _____ Date _____ Exp. _____
Have you been recertified? Yes No Date _____ Exp. _____
If status is qualified, give date status expires. Date _____
If qualified, date exam(s) scheduled. Date _____ Date _____
WRITTEN EXAM ORAL EXAM
Board certification results pending? Yes No

SECONDARY SPECIALTY _____ Qualified Certified Does not apply
Certifying Board _____ Date _____ Exp. _____
Have you been recertified? Yes No Date _____ Exp. _____
If status is qualified, give date status expires. Date _____
If qualified, date exam(s) scheduled. Date _____ Date _____
WRITTEN EXAM ORAL EXAM
Board certification results pending? Yes No

CPR CERTIFICATIONS

Are you certified in CPR? Yes – attach copy of certificate(s) Expiration Date _____
 No

Check Classification(s): Basic Life Support (BLS) Expiration Date _____
 Advanced Cardiac Life Support (ACLS) Expiration Date _____
 Health Care Provider (Core C) Expiration Date _____
 Advanced Trauma Life Support (ATLS) Expiration Date _____
 Neonatal Resuscitation Program (NRP) Expiration Date _____
 Pediatric Life Support (PALS) Expiration Date _____

Other professional certifications or credentials (please include description):

PROVIDER NUMBERS:

If you currently have any of the following provider numbers, please list them below:

Ohio Medicare PIN #: _____ National Provider # (UPIN): _____
Ohio Medicaid Provider #: _____ Bureau of Worker’s Compensation #: _____

EDUCATION AND TRAINING

UNDERGRADUATE EDUCATION

University _____
Address/Street _____
City/State/Zip _____
Degree _____ From _____ To _____

MEDICAL EDUCATION

University _____
Address/Street _____
City/State/Zip _____
Degree _____ From _____ To _____

OTHER GRADUATE LEVEL EDUCATION FOR WHICH A DEGREE WAS OBTAINED

University _____
Address/Street _____
City/State/Zip _____
Degree _____ From _____ To _____

INTERNSHIP

Facility _____

Address/Street _____

City/State/Zip _____

Specialty _____ From _____ To _____

Supervisor _____

RESIDENCY

Facility _____

Address/Street _____

City/State/Zip _____

Specialty _____ From _____ To _____

Supervisor _____

RESIDENCY

Facility _____

Address/Street _____

City/State/Zip _____

Specialty _____ From _____ To _____

Supervisor _____

FELLOWSHIP

Facility _____

Address/Street _____

City/State/Zip _____

Specialty _____ From _____ To _____

Supervisor _____

FELLOWSHIP

Facility _____

Address/Street _____

City/State/Zip _____

Specialty _____ From _____ To _____

Supervisor _____

ADDITIONAL QUALIFICATIONS OR TRAINING

Facility _____
Address/Street _____
City/State/Zip _____
Specialty _____ From _____ To _____
Supervisor _____

INTERNATIONAL MEDICAL GRADUATES

Are you certified by the Educational Council for Foreign Medical Graduates? Yes No

ECFMG# _____ Date Issued _____

EMPLOYMENT HISTORY

Please list practice settings, hospital affiliations, military experience, or places of employment over the past five years or since completion of training shown above. If more space is needed, please include an attachment.

Practice location or Employer: _____

Address: _____

City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____

Dates of employment/practice: From _____ To _____

Reason for leaving: _____

Practice location or Employer: _____

Address: _____

City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____

Dates of employment/practice: From _____ To _____

Reason for leaving: _____

Practice location or Employer: _____

Address: _____

City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____

Dates of employment/practice: From _____ To _____

Reason for leaving: _____

Practice location or Employer: _____

Address: _____

City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____

Dates of employment/practice: From _____ To _____

Reason for leaving: _____

Please explain any lapse in training or employment below:

REFERENCES

Please list the name of four colleagues who can attest to your current clinical competence. **One of your references must be your most recent supervisor.**

Name: _____

Address/Street: _____

City/State/Zip Code: _____

Phone: (____) _____ Fax: (____) _____ e-mail: _____

Relationship: _____

Name: _____

Address/Street: _____

City/State/Zip Code: _____

Phone: (____) _____ Fax: (____) _____ e-mail: _____

Relationship: _____

Name: _____

Address/Street: _____

City/State/Zip Code: _____

Phone: (____) _____ Fax: (____) _____ e-mail: _____

Relationship: _____

Name: _____

Address/Street: _____

City/State/Zip Code: _____

Phone: (____) _____ Fax: (____) _____ e-mail: _____

Relationship: _____

DOCUMENTS TO SUBMIT WITH THIS APPLICATION:

- Curriculum Vitae
- Current Malpractice Insurance Certificate
- Signed Participation Agreement
- Copy of Ohio Special Activities License (if not currently licensed in the state of Ohio)

PROFESSIONAL STATUS

Please respond to the following questions:

	YES	NO
1. Has your license to practice medicine been voluntarily or involuntarily limited, relinquished, refused, suspended, revoked, or restricted or are there currently any pending challenges to your licensure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your license to prescribe narcotics been voluntarily or involuntarily limited, relinquished, refused, suspended, revoked, or restricted or are there currently any pending challenges to your registration?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been denied requests for hospital privileges?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever resigned or been asked to resign from a Medical Staff or professional society?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has any hospital ever suspended, diminished, revoked or failed to renew your privileges?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been convicted of a felony or are you involved in any current criminal charge or investigation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been denied membership or renewal thereof, or been subject to disciplinary proceedings of any medical organization?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you had professional liability insurance declined, canceled, issued on special terms or renewal refused?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you been the subject of a malpractice claim or defendant in a malpractice suit at any time in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you currently ineligible to participate in Medicare/Medicaid programs?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been sanctioned or disciplined in any way by the Federal and/or State Medicare/Medicaid programs or are you currently under investigation involving violation of Medicare/Medicaid laws or any matter involving private insurance billing?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered “YES” to any of the above questions, a full statement of explanation must be attached.

STATEMENT OF HEALTH

Each applicant must answer one of the following questions:

- 1. I certify that I am in good health, do not presently use illegal drugs, and have no physical or mental limitations that would compromise my ability to perform any of the mental and physical functions related to the specific privileges requested.
- 2. I do have a chronic illness, physical disability and/or mental limitations to my health, which may include alcohol or drug use, but believe this does not significantly impair my ability to render quality patient care.

If you answered #2 above, a full statement of explanation must be attached, including reasons for any inability to perform the essential functions of the position, with or without accommodation. This statement must include the name and address of your personal physician.

INFORMATION AUTHORIZATION AND CONDITIONS OF APPLICATION

By submitting application to CAST at The Cleveland Clinic Foundation, I hereby:

- signify my willingness to appear for interviews in regard to my application; authorize The Cleveland Clinic, the Professional Staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications, as required by CAST.
- consent to inspection and copying of records and documents that may be material to an evaluation of my qualifications and authorize individuals and organizations in custody of such records to permit such inspection and copying;
- consent to the release of such information;

INITIAL IN BOX BELOW

release from liability all representatives of The Cleveland Clinic and its Professional Staff for their acts performed and statements made in good faith concerning my professional competence, ethics, character and other qualifications

INITIAL IN BOX BELOW

release from liability any and all individuals and organizations who provide information to The Cleveland Clinic or the Professional Staff in good faith, concerning my professional competence, background, experience, ethics, character, utilization practice patterns, health status and other qualifications

INITIAL IN BOX BELOW

release from any liability, to the fullest extent permitted by law, all persons for their acts performed in investigating and evaluating any and all information pertaining to this application;

- agree to inform the CAST office of any change made or proposed in the status of my professional license to practice, DEA or other controlled substances registrations, professional liability insurance coverage, membership or clinical privileges at other institutions, on the status of current, or initiation of new, malpractice claims, and any changes made or formal action initiated that could result in a change of participation in any program or plan for the reimbursement of services;
- authorize all malpractice insurance carriers (past and present) to release to the Cleveland Clinic Foundation all information regarding my malpractice status;
- acknowledge that any significant misstatements in, or omissions from, this application constitute cause for denial of my application

All information submitted by me in this application is true and complete to my best knowledge and belief. A photostatic copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to this application.

Date: _____ Signature: _____

The Cleveland Clinic Health System will treat this application and any information secured in connection with it in confidence and will employ reasonable safeguards to prevent the unauthorized disclosure of any such information.

**** A copy of this statement shall be as binding as the original ****